Evidence for addition of date of birth is shown on

FILM No. G98 OCT 9 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

CERTIFICATE OF DEATH

69042

★ Reg. Dist. No. 163

1. PLACE OF DEATH:
County Garrett
City or town Bloomington, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 54 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Brendlen

3.(b) Social Security Number 236-03-3828

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Brendlen
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): January 10, 1891

8. AGE:	Years	Months	Days	If less than one day
	54			hrs. min.

9. Birthplace: Hyndman-Bedford-Penn.
(Town, county, and state)
10. Usual occupation: Miner
11. Industry or business: Coal Mine
FATHER 12. Name: Charles Brendlen
13. Birthplace: Germany
MOTHER 14. Maiden name: Amanda Fisher
15. Birthplace: Not Known
16. Informant: Mrs. Mary Brendlen
Address: Bloomington, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 30, 45. (month) (day) (year)
Cemetery or crematory: Bloomington
Location: Bloomington, Md.
18. Funeral director: Ellsworth Boal
Address: Westernport, Md.
19. 9-29 19 45 Dorcy Pattison
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 27, 1945 at 3.30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4 1944 to Sept. 27 1945
and that I last saw him alive on Sept. 27 1945
Immediate cause of death: Coronary Thrombosis — DURATION: 1 yr
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: E Berry M.D.
M. D. or other
Address: Piedmont W Va — Date signed: 9/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19-a)

CERTIFICATE OF DEATH

09643

Reg. Diat. No. 64

1. PLACE OF DEATH:

County: Garrett

City or town: Accident, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred: Home

How long in hospital or institution? 0

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Rural Accident, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Near Accident, Maryland
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Charles Burkhard

3. (b) Social Security Number: 0

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Burkhard

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): ~~March~~, Nov. 27, 1868

8. AGE:

Years	Months	Days	If less than one day
76	10		...hrs. ...min.

9. Birthplace: Accident, Maryland
(Town, county, and state)

10. Usual occupation: Farming

11. Industry or business: Farm

FATHER
12. Name: Leonard Burkhard
13. Birthplace: Bern, Germany

MOTHER
14. Maiden name: Magaline
15. Birthplace: Bern, Germany

16. Informant: ~~W~~ L. Burkhard

Address: Accident, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-28-45 (month) (day) (year)

Cemetery or crematory: Zion Lutheran

Location: Accident Md

18. Funeral director: Wm. Winebrenner

Address: grantsville

19. Sept. 26 1945 (Date rec'd by registrar) Emmard Spaerlein Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 25 1945 at 4:55 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3, 1941 to Sept. 25, 1945 and that I last saw him alive on July 7 1945

Immediate cause of death	DURATION
Coronary Thrombosis	5 min.
Due to: Generalized Arteriosclerosis - ?	
Due to: Senility	
Other conditions: Chronic Nephritis; high blood pressure.	?

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. J. Glover, M.D. M. D. or other

Address: Friendsville Maryland Date signed: Sept. 26 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

C9644

Reg. Dist. No. 168

1. PLACE OF DEATH:
County: Garrett
City or town: Grimes Road
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give recidence of mother)
State: Maryland County: Garrett
City or town: Frostburg - rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Nancy M. Caton

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

8.(b) Name of husband or wife: Geo Caton
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 15 - 1875

8. AGE: Years	Months	Days	If less than one day
69	10	25	..... hrs. ..... min.

9. Birthplace: Somerset Co. Pa.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Solomon Albright
13. Birthplace: Pa.

MOTHER
14. Maiden name: Catherine Gault
15. Birthplace: Pa

18. Informant: Ellen McKenzie
Address: Route 2 Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 12-1945 (month) (day) (year)
Cemetery or ~~crematory~~: Greenville
Location: Greenville, Pa.

18. Funeral director: J. J. Hunt
Address: Frostburg, Md

19. Sept. 11 - 1945. (Date rec'd by registrar) Mrs Julius Michael (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 9 1945 at 5 00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1st 1941 to September 9 1945 and that I last saw h... alive on 9/1 1945

Immediate cause of death	DURATION
Hypertensive Heart disease	4 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hilda Lourle Walters M.D.
M. D. or other
Address: Frostburg Date signed 9/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

09045

CERTIFICATE OF DEATH

Reg. Dist. No. 168

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Garett

City or town: Rural Near Frostburgon R-40
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): I-Year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Garett

City or town: Rural Near Frostburg On-R-40 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.:
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR:

3. (a) FULL NAME: David Emerson

3. (b) Social Security Number: 214-05-9848

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife: Rella A. Emerson

6(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): November 15-1882

8. AGE: Years	Months	Days	If less than one day
62	10	9	hrs. min.

9. Birthplace: Lonaconing Md
(Town, county, and state)

10. Usual occupation: Rubber Tire Worker

11. Industry or business

FATHER
12. Name: Stephen Emerson
13. Birthplace: Engeland

MOTHER
14. Maiden name: Grace Emerson
15. Birthplace: Engeland

16. Informant: Mrs Rella Emerson
Address: Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 27-1945 (month) (day) (year)

Cemetery or crematory: Alagany

Location: Frostburg Md

18. Funeral director: Allen Winterberg

Address: Grantsville Md

19. Sept 27 1945 (Date rec'd by registrar) Mrs Julius Michael Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 25 1945, at 9 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Examined after death 19..., and that I last saw h... alive on ... 19...

Immediate cause of death: Coronary Occlusion — DURATION

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Oakland Md Date signed: 9/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

19646

★ Reg. Dist. No. 166

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Garrett

City or town Mt. Lake Park

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Rest Home Mt. Lake Park MD

Stay in hospital or inst. (yrs., or mos., or days) 3 yrs

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett

City or town Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME Albert Hilemon

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 10. 1865

8. AGE:

Years	Months	Days	If less than one day
80			hrs. min.

9. Birthplace Accident Garrett Co. MD

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Samuel Hilemon

13. Birthplace Unknown

MOTHER 14. Maiden name Sophia Sears

15. Birthplace Unknown

16. Informant Wm A. Winterberg

Address Grantsville MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 24. 1945 (month) (day) (year)

Cemetery or crematory Hebb

Location Nr. Accident MD RD #2

18. Funeral director Wm A. Winterberg

Address Grantsville MD

19. 9/27/1945 (Date rec'd by registrar) Julia A. Rowan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 21 1945, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Examined after death 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Occlusion	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. D. Baumgartner M. D. Dep. Med. Examiner Garrett Co. MD

M. D. or other

Address Oakland MD Date signed 9/21/45

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

69047

Reg. Diat. No. 162

1. PLACE OF DEATH:
County: Garett
City or town: Grantsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Garett
City or town: Grantsville
(If ontside city or town limits, write RURAL and givn nenrest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Fay Lester Miller

3. (b) Social Security Number: 2I4-03-7II3

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mary Ethel Miller
6.(c) If alive, give age: 5I years
7. Birth date of deceased (mo., day, yr.): September I7. I894

8. AGE: Years	Months	Days	If less than one day
50	II	27	hrs. min.

9. Birthplace: Markelton Somerset Co Pa (Town, county, and state)
10. Usual occupation: Resturant Operator
11. Industry or business

FATHER
12. Name: Wm Henry Miller
13. Birthplace: R.D.3 Meyersdale Pa

MOTHER
14. Maiden name: Myrtel B. Pelere
15. Birthplace: Mercer Pa

16. Informant: Mrs Ethel Miller
Address: Grantsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-I6-I945 (month) (day) (year)
Cemetery or crematory: Grantsville
Location: Grantsville Md

18. Funeral director: Wm Winterberg
Address: Grantsville Md

19. Sept 15 45 Ethel Broadwater
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 14 19 45, at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 16 19 45, to Sept 14 19 45 and that I last saw h[illegible] alive on Sept 9 19 45

Immediate cause of death	DURATION
Hemorrhage	1 week
Due to acd chronic peptic ulcer	10 yrs.
Due to	
Other conditions Tabes dorsales	unkn

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Alexander Solokoff M. D. or other
Address: Salisbury Pa Date signed 9/15/45

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

69048

★ Reg. Diat. No. 164

1. PLACE OF DEATH:
County Garett
City or town R.D.2 Accident
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Garett
City or town R.D.2 Accident Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Anna Mae Riley

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife Bernard Riley
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 29 I893

8. AGE: Years	Months	Days	If less than one day
52	2	I3	hrs. min.

9. Birthplace R.D.2 Accident Md (Town, county, and state)
10. Usual occupation House Work
11. Industry or business

FATHER
12. Name Stephen Speicher
13. Birthplace Bittinger Md

MOTHER
14. Maiden name Mary Beachley
15. Birthplace R.D.2 Accident Md

16. Informant Miss Grace Riley
Address Grantsville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-I4-I945 (month) (day) (year)
Cemetery or crematory Cove
Location R.D.2 Accident Md

18. Funeral director Wm Winterberg
Address Grantsville Md

19. Sept 18 1945 (Date rec'd by registrar) Edmund D Spoerlein Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September II 1945 at 8 a.m. P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5-31- 1945, to 8-25 1945
and that I last saw h-er alive on 8-25 1945

Immediate cause of death	DURATION
Carcinoma Right Breast	9 mo
Due to	
Due to	
Other conditions Metastases to lungs	2 mo

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. Rhett Rathbone M.D. M. D. or other
Address Memorial Hospital Cumberland, Md Date signed 9-13-45

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

19049

Reg. Dist. No. 166

1. PLACE OF DEATH:
County: Garrett
City or town: Mt. Lake Park, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life time
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Garrett
City or town: Mt Lake Park md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME (Lower)
Mrs. Stella May Roy.

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Deceased
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 8th, 1876

8. AGE: Years	Months	Days	If less than one day
69	3	27	..... hrs. ..... min.

9. Birthplace: Garrett County.
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business

FATHER
12. Name: Henry Lower.
13. Birthplace: Garrett County.

MOTHER
14. Maiden name: Roxilana Lipscomb.
15. Birthplace: Preston, County.

16. Informant: Mrs. Clayton Winters.
Address: Oakland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 5th/45 (month) (day) (year)
Cemetery or crematory: Thayerville Cemetery.
Location: Thayerville, Md.

18. Funeral director: Emroy D. Bolden.
Address: Oakland, Md.

19. 9-4- 45 (Date rec'd by registrar) Julia Lawson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 2nd 19 45, at 6:3 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-2- 45 to 9-2- 45 and that I last saw h alive on 19

	DURATION
Immediate cause of death: Heart Attach	1 day
Due to:	
Due to:	
Diabetis	6 mo
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edwin A. Lawson M. D. or other
Address: Oakland, Md. Date signed 9-4-45

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

D 9050

Reg. Dist. No. 166

1. PLACE OF DEATH:

County Garrett

City or town Oakland, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Garrett

City or town Oakland Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Urias Sines.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Dora Sines.

6.(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) July 18th, 1875.

8. AGE: Years	Months	Days	If less than one day
70	1	20	..... hrs. ..... min.

9. Birthplace Sines, Maryland. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Henry Sines.

13. Birthplace Sines, Maryland.

MOTHER 14. Maiden name Susan Sines.

15. Birthplace Sines, Maryland.

16. Informant Russel Leighton.

Address Oakland, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 9th/45 (month) (day) (year)

Cemetery or crematory Sines Cemetery.

Location Sines, Maryland.

16. Funeral director Emroy D. Bolden.

Address Oakland, Maryland.

19. 9-8- 19 45 Julia Lowman Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 7 19 45, at 945 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 1943, to Sept 19 45

and that I last saw h.. alive on Sept. 7 19 45

Immediate cause of death Chronic Myocarditis — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E. D. Baumgartner M.D. M. D. or other

Address Oakland Md Date signed 5/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73a)

CERTIFICATE OF DEATH

09651

★ Reg. Diat. No. 162

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Garett
City or town: Grantsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? I Year
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Garett
City or town: Grantsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Blanch Delena Swager

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Leland Swager
6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): October 21-1905

8. AGE: Years	Months	Days	If less than one day
39	IO	I2	....hrs. ....min.

9. Birthplace: Avilton Garett Co Md
(Town, county, and state)
10. Usual occupation: House Work
11. Industry or business
FATHER 12. Name: Richard T. Layman
13. Birthplace: Avilton Garett Co. Md
MOTHER 14. Maiden name: Anna H. Miller
15. Birthplace: R.D.2 Grantsville Md
16. Informant: Mrs Margaret Miller
Address: Grantsville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-4-1945 (month) (day) (year)
Cemetery or crematory: Grantsville
Location: Grantsville Md
18. Funeral director: Wm Winterberg
Address: Grantsville Md
19. Sept 3 19 45 Ethel Broadwater
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 2 1945 at 8:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Sept 2 1945
and that I last saw her alive on Sept 1 1945

Immediate cause of death	DURATION
Pernicious Anemia	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. R. Davis M.D. M. D. or other
Address: Grantsville Md Date signed: Sept 7-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

00652

Reg. Dist. No. 166

1. PLACE OF DEATH:
County: Garrett
City or town: Deer Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred: ----
How long in hospital or institution? ----

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Garrett
City or town: Deer Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. ---
(If rural, give LOCATION)
2.(a) If veteran, name war: ----

3.(a) FULL NAME: Onia Cunningham Uhl

3.(b) Social Security Number: ----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Clark Uhl
6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): March 7, 1872

8. AGE: Years	Months	Days	If less than one day
73	6	19	....hrs. ....min.

9. Birthplace: Calhoun Co., W. Va.
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business: Own Home
FATHER 12. Name: William Cunningham
13. Birthplace: W. Va.
MOTHER 14. Maiden name: Mattie Ferril
15. Birthplace: W. Va.
16. Informant: Mrs. Pearl Browning
Address: Deer Park, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/28/45 (month) (day) (year)
Cemetery or crematory: Deer Park Cemetery
Location: Deer Park, Md.
18. Funeral director: Herbert R. Leighton
Address: Oakland, Md.
19. 9/27/45 (Date rec'd by registrar) Julia Rowan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26 19 45 at 4:40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 43 to Sept 25 19 45
and that I last saw h... alive on Sept 25 19 45

	DURATION
Immediate cause of death: Acute Bronchitis	1 wk
Due to:	
Due to:	
Other conditions: Diabetes Mellitus, Carcinoma of Breast (Include pregnancy within 3 months of death)	

Major findings of operations: ....Date of op. ....
Autopsy results: ....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE: L. J. Baumgartner M.D. M. D. or other
Address: Oakland Md Date signed 9/27/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09053

Reg. Dist. No. 162

1. PLACE OF DEATH:

County: Garett

City or town: Jennings

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Garett

City or town: Jennings

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elmer Ellsworth Weimer

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Laura Isabelle Weimer

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): April 17- 1867

8. AGE: Years	Months	Days	If less than one day
78	4	21	hrs. min.

9. Birthplace: Kingwood W.Va

(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER 12. Name: BenJamine Weimer

13. Birthplace: Not Knowen

MOTHER 14. Maiden name: Martha Savage

15. Birthplace: Not Knowen

16. Informant: Mrs William Hindbaugh

Address: Oakland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-10- 1945 (month) (day) (year)

Cemetery or crematory: Thayerville

Location: Thayerville Md

16. Funeral director: Omar Winterberg

Address: Grantsville Md

19. Sept 10 1945 (Date rec'd by registrar) Ethel Broadwater Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 7 1945, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1945 to Sept 7 1945

and that I last saw him alive on Sept 6 1945

Immediate cause of death	DURATION
Cerebral Haemorrhage	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: L. R. Davis M.D. M. D. or other

Address: Grantsville Md Date signed: Sept 7

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15